PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS
David Stager, Jr., MD, FACS, FAAP | David Stager, Sr., MD, FACS
Becky Luu, OD | Reed Jost, MS

COVID - 19 SCREENER

1. Have you had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt "feverish" or had a temperature that is elevated for you/100.0F or greater?	❑ No ❑ Yes
2. Do you have any of the following symptoms? ○ Cough ○ Shortness of Breath or Chest Tightness ○ Sore Throat ○ Nasal Congestion/Runny Nose ○ Myalgia (Body Aches) ○ Loss of Taste and/or Smell ○ Diarrhea ○ Nausea ○ Vomiting ○ Fever/Chills/Sweats	❑ No ❑ Yes, ❑ If so - what symptoms?
3. Have you been in contact within the last 20 days with someone with a confirmed diagnosis of COVID-19 or traveled to New York, New Jersey, or Connecticut?	❑ No ❑ Yes
4. Have you had any international travel in the last 20 days?	❑ No ❑ Yes - Where?

Patient Name: _____ Patient/Guardian Signature: _____

Accompanied by: _____

Relationship to patient: _____ Signature: _____